Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name
ACE AMERICAN INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-08-3238-01

MFDR Date Received
January 22, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our company has purchased national hospital payment data from 'Cleverly and Associates'; a nationally recognized company. This data is known as Med Par Data, based on this data, we have established a PAF or payment adjustment factor to be applied to our hospital specific Medicare OPPS reimbursement rate and determined this to be our interpretation and application of fair and reasonable. . . .The PAF we have established is 250.00% of our hospital specific Medicare Outpatient Prospective Payment System reimbursement rate, which is consistent with most commercial and private payers with in this region."

Amount in Dispute: $4,040.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that $2,236.00 represents an amount greater than or equal to the fair and reasonable reimbursement for this service. The provider must therefore prove that the reimbursement received is not fair and reasonable. . . . Because Requestor has failed to prove that the reimbursement received is not fair and reasonable, Requestor is not entitled to further reimbursement."

Response Submitted by: XXXX

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 4, 2007	Outpatient Hospital Services	$4,040.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of services not identified in an established fee guideline.
3. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.
4. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of In re: Renaissance Hospital - Grand Prairie, Inc. d/b/a/ Renaissance Hospital - Grand Prairie, et al., in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 142 – Charge included in facility fee
   - W10 – Payment based on fair & reasonable methodology.
   - B15 – Procedure Service is not paid separately
   - 529 – Facility allowance
   - 352 – Network disc not applicable to procedure billed
   - B29 – Apportioned Claim – 50% Allowed
   - W4 – No additional payment allowed after review

Findings

1. The insurance carrier reduced or denied disputed services with reason code 352 – “Network disc not applicable to procedure billed.” Review of the submitted information found no documentation to support that the disputed services were subject to a contractual agreement between the parties to this dispute. Nevertheless, on June 11, 2011, the Division requested the respondent to provide a copy of the referenced contract(s) between the health care provider and the alleged network pursuant to former 28 Texas Administrative Code §133.307(e)(1), effective December 31, 2006, 31 Texas Register 10314, which states that “The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available.” No further information has been received from the respondent; therefore this decision is based on the information available at the time of this review. The respondent has not otherwise submitted documentation to support that the services in this dispute are subject to a contractual fee arrangement or network discount. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to outpatient services performed in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 2, 2006, Volume 31 Texas Register, page 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(E), effective December 31, 2006, 31 *Texas Register* 10314,

applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. The requestor did not submit a copy of any nursing notes, anesthesia record, discharge summary or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).

5. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Our company has purchased national hospital payment data from 'Cleverly and Associates'; a nationally recognized company. This data is known as Med Par Data, based on this data, we have established a PAF or payment adjustment factor to be applied to our hospital specific Medicare OPPS reimbursement rate and determined this to be our interpretation and application of fair and reasonable. . . .The PAF we have established is 250.00% of our hospital specific Medicare Outpatient Prospective Payment System reimbursement rate, which is consistent with most commercial and private payers with in this region."
   - Review of the submitted information finds that the data does not support the reimbursement amount sought by the requestor.
   - The requestor did not explain how it determined that a payment adjustment factor of 250% of the hospital specific Medicare Outpatient Prospective Payment System reimbursement rate would result in a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that a payment adjustment factor of 250% of the hospital specific Medicare Outpatient Prospective Payment System reimbursement rate would result in a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that this rate is consistent with most commercial and private payers in the region.
   - The requestor has not supported that payment of the requested amount would satisfy the requirements of Division rule at 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amounts sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

	Grayson Richardson	June 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.